NORTH DAKOTA IDENTIFICATION SCREENING FORM

Level I Screening Form Must Remain in the Individual's Record and a Copy Transferred with the Individual in any New Placements

Patient Name: _____ Payment Status: ☐ Medicaid ☐ Medicare ☐ Private Pay/Private Insur.

c/o: _____ MID #: _____ ☐ Male ☐ Female

Address: _____ DOB: _____ Marital Status: _____

_____ ☐ Initial Level I ☐ Status Change Admit Date: _____

County: _____ Admitting Facility: _____

Referral Agency: _____ Contact Person: _____

Contact Person: _____ Admittng Address: _____

Referral Address: _____ Admitting Phone: _____

Referral Phone: _____ Patient Current Living Situation

Social Security#: _____ ☐ NF ☐ Basic Care ☐ Hospital ☐ Other_____

SECTION I: MENTAL ILLNESS SCREEN

1.A. Psychiatric Diagnoses None ☐

☐ Anxiety/panic disorder ☐ Psychotic disorder
☐ Major Depression ☐ Somatoform disorder
☐ Delusional Disorder ☐ Schizophrenia
☐ Schizoaffective disorder ☐ Eating disorder (specify)
☐ Bipolar Disorder "manic depression"_____
☐ Personality disorder (specify) _____
☐ Other: _____

1.B. Psychiatric Meds **Dosage/Start date** None ☐

_____ _____
_____ _____
_____ _____
_____ _____

DDM USE ONLY: Meets diagnosis criteria for chronicity?

☐ Y ☐ N ☐ UTD

2.A. Psychiatric treatment in past 2 years (give dates): None ☐

☐ Inpatient psych. hosp. _____
☐ Partial hosp./day treatment _____
☐ Other _____

2.B. Intervention to prevent hospitalization (give dates): None ☐

☐ Supportive living due to MI _____
☐ Housing intervention due to MI _____
☐ Legal intervention due to MI _____
☐ Suicidal ideation and/or attempt _____
☐ Other _____

DDM USE ONLY: Meets criteria for duration:

☐ Y ☐ N ☐ UTD

3. Role limitations in past 6 months due to MI: None ☐

Indicate: "F" *Frequently*, "O" *Occasionally*, or "N" *Never*

3. A. Interpersonal Functioning (exclude problems w/medical basis)

F O N Altercations
F O N Evictions
F O N Fear of strangers
F O N Suicidal talk
F O N Illogical comments
F O N Other _____
F O N Social isolation/avoidance
F O N Excessive irritability
F O N Easily upset/anxious
F O N Hallucinations
F O N Serious communication difficulties
F O N Other _____

Notes: _____

3.B. Concentration/Task limitations within past 6 months due to MI (exclude problems with medical basis): None ☐

F O N Serious difficulty completing age related tasks.
F O N Serious loss of interest in things.
F O N Serious difficulty maintaining concentration/ attention.
F O N Numerous errors in completing tasks which she/he should be physically capable.
F O N Requires assistance with tasks for which she/he should be physically capable of accomplishing.
F O N Other _____

Notes: _____

3.C. Significant problems adapting to typical changes within 6 months due to MI (exclude medically based problems):

Y N Requires mental health intervention due to increased symptoms. None ☐
Y N Requires judicial intervention due to symptoms.
Y N Symptoms have increased as a result of adaptation difficulties.
Y N Serious agitation or withdrawal due to adaptation difficulties.
Y N Other _____

Notes: _____

DDM USE ONLY: **MI Decision:**

Meets criteria for disability: ☐ Y ☐ N ☐ UTD

Meets criteria for SMI: ☐ Y ☐ N ☐ UTD

SECTION II: MENTAL RETARDATION AND RELATED CONDITIONS SCREEN

1.A. MR diagnosis: ☐ N ☐ Y (specify) _____

B. Undiagnosed but suspected MR: ☐ N ☐ Y ☐ N/A

C. History of receipt of MR services: ☐ N ☐ Y

(if yes, specify): _____

D. Onset before age 18: ☐ N ☐ Y ☐ Unknown

(if yes, specify age): _____

2.A. Diagnosis which impairs intellectual or adaptive functioning?

☐ None
☐ Cerebral Palsy ☐ Autism ☐ Epilepsy ☐ Deaf
☐ Closed Head Injury ☐ Blind ☐ Other _____

B. Are there substantial functional limitations in any of the following:

☐ None ☐ Mobility ☐ Self Care
☐ Self-direction ☐ Capability for independent livin ☐ Learning
☐ Understanding/use of language

C. If a condition is identified in 2.A, did it develop before age 22?

☐ N/A ☐ N ☐ Y (specify) _____

DDM USE ONLY: Meets criteria for MR/RC

MR Decision: ☐ Y ☐ N ☐ UTD

NDL1MAY2003

"CONFIDENTIAL"

LEVEL I SCREENING FORM CONTINUED ON NEXT PAGE

Patient Name: _____

S.S.#: _____

North Dakota Identification Screening Form
Page Two

STOP HERE IF MI & MR DECISIONS ARE BOTH "NO". OTHERWISE CONTINUE.

SECTION III: DEMENTIA (complete for both MI & MR)

A. Does the individual have a primary diagnosis of Dementia or Alzheimer's Disease?
☐ N ☐ Y (specify) _____

B. Does the individual have any other organic disorders?
☐ N ☐ Y (specify) _____

C. Identify the individual's status with regard to the following:

Y N disoriented to time
Y N disoriented to place
Y N paranoid ideation
Y N disoriented to situation
Y N pervasive, significant confusion
Y N severe ST memory deficit

D. Identify the presence/absence of any affective symptoms as follows:

Y N frequent tearfulness
Y N frequent anxiety
Y N severe sleep disturbance
Y N severe appetite disturbance

E. If dementia/Alzheimer's is suspected, is there corroborative testing or other information to verify its progression or status as primary?
☐ Dementia work-up ☐ No ☐ N/A
☐ Comprehensive mental status exam
☐ Other (Specify)_____

DDM USE ONLY:
Does the individual have a primary dementia diagnosis?
Dementia decision: ☐ **Y** ☐ **N** ☐ **UTD**

Documentation must be provided to support diagnosis of Primary Dementia

IF "YES" FOR MI PATIENT, STOP HERE.
CONTINUE FOR ALL MR/RC PATIENTS AND FOR MI PATIENTS WHO DID NOT MEET DEMENTIA EXEMPTION.

SECTION IV: CONVALESCENT CARE EXEMPTION

A. Does the admission meet all of the following criteria?
☐ Admission to a NF directly from the hospital after receiving acute medical care in the hospital; and
☐ Need for NF care is required for the condition for which care was provided in the hospital; and
☐ The attending physician has certified prior to nursing facility admission that the individual will require less than 30 calendar days NF services.

*** Individuals meeting all criteria are exempt from Level II screens for 30 calendar days. The receiving facility must update Level I and NF level of care screens at such time that it appears the individual's stay will exceed 30 calendar days. Screens must be updated on or before the 30th calendar day.**

DDM USE ONLY:
Meets convalescent exemption: ☐ **Y** ☐ **N**
Expiration Date: _____
STOP HERE IF "YES"

SECTION V: CATEGORICAL DETERMINATION

If the individual meets one of the following 2 criteria, s/he may be admitted for up to calendar days:

A. ☐ Provisional emergency: *emergency protective services situation necessitating NF care for no greater than 7 calendar days*

B. ☐ Provisional Delirium: *presence of delirium precluded the ability to make accurate diagnosis and the patient's Level I Screen will be updated no greater than 7 calendar days following admission.*

DDM Use Only: Meets categorical criteria:
☐ **Y** ☐ **N**
Expiration Date: _____

DDM May2003

Mailing Information:

Guardian/POA/Court Appointed Guardian's name and address:

_____

_____

_____

Primary physician's name and address:

_____

_____

_____

ATTACH ANY ADDITIONAL NOTES ON A SEPARATE PAGE.

Comments/Notes:

Send to:

Dual Diagnosis Management (DDM)
ATTN: ND LTC
220 Venture Circle; Nashville, TN 37228
Phone: 877/431.1388
Fax: 877/431.9568

DDM DETERMINATION (OFFICE USE ONLY)

☐ **Requested Additional Information**

Request Date_____ **Received Date**_____

☐ **Level I Approved (No Level II Required)**

Time Limited? ☐ **N** ☐ **Y**
If so, specify end date_____

☐ **Level II Required**
☐ **MI** ☐ **MR** ☐ **RC**

_____
DDM Reviewer Signature

_____
Date